CMU HEALTH
CENTRAL MICHIGAN UNIVERSITY

CONSENT FOR TREATMENT/PAYMENTS/HEALTHCARE OPERATIONS

Consent for Services

I request and authorize healthcare services as my physician or other provider, his/her assistants, or designees (collectively called "the Providers") may deem necessary or advisable. This care may include, but is not limited to, routine diagnostic and laboratory procedures, administration of routine drugs, and other therapeutics and routine medical and nursing care. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me with respect to such diagnostic procedures or treatments.

I am aware that CMU Health is a teaching facility and that resident physicians and medical students may be involved with my care under the supervision of a staff physician. I consent to their involvement and participation in my treatment.

I consent to the photographing, photo copying, or televising of the operation or procedure(s) to be performed, including appropriate portions of my body, for medical, scientific, or educational purposes, provided my identity is not revealed by picture or text.

Payment Authorization

I authorize CMU Health to furnish information to insurance carriers concerning my illness and treatments. I hereby assign to the physician(s) all payment for medical services rendered to my dependents and/or myself. I assume full financial responsibility for payment of all services provided to me, including any portion of my bill which is not paid by insurance, workers compensation or any other agency.

Co-Pay Agreement

A $5.00 processing fee may be charged if your co-pay is not paid at the time services are rendered. I understand and authorize this fee.

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices that describes how my health information is used and shared. I understand that CMU Health has the right to change this notice at any time. I may obtain a current copy at any time by contacting CMU Health or by visiting the website at http://med.cmich.edu/patients. I have the right to revoke this consent, in writing, at any time, except to the extent that CMU Health has taken action in reliance on this consent.

I understand that under certain circumstances, CMU Health may use and disclose my health information for teaching or research purposes. This research generally is subject to oversight by an institutional review board to protect patient safety, welfare and confidentiality. The institutional review board evaluates a proposed research project and its use of health information to balance the benefits of research with the need for privacy of health information. Even without special approval, I understand and approve the use of my health information for allowing researchers to look at records to help them identify patients who may be included in a research project or for similar purposes. My health information may be used or disclosed for research as "limited or de-identified data sets" which do not include name, address or other direct identifiers.

Acknowledgement of Receipt of the Patient Centered Medical Home (PCMH) Patient-Provider Agreement

I have received a copy of the Patient Centered Medical Home (PCMH) Patient-Provider Agreement, which describes my responsibilities as a patient and those of my CMU Health care team. I understand my responsibilities as outlined in this agreement. I may obtain additional copies of this agreement at any time by contacting CMU Health or by visiting the website http://med.cmich.edu/patients.

I read and understand everything on this form and consent fully and voluntarily to its contents.

Patient Signature _____ Date: _____

Patient Name (print): _____

Parent/Guardian Signature: _____ Date _____

Parent/Guardian Name (print): _____

(Rev. 1-23-23)

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PATIENT COMMUNICATION FORM - ADULT

The purpose of the form is for you to document your preferences regarding 1) how we communicate with you and 2) if/how you would like us to communicate with your friends and family regarding your care. Filling out this form will allow us to <u>verbally</u> share information with the individuals you specify. Any request to disclose <u>written</u> information, including but not limited to any information in your medical record, will only occur after a written authorization has been completed and signed.
You may revoke this permission at any time by completing a new Patient Communication Form.

COMMUNICATIONS WITH ME

Telephone Contact# Home ( )_____ Cell ( ) _____
Preferred: Home ____ Cell____

If unable to reach me:
_____ I give practice staff consent to identify themselves and leave verbal messages for me or to send text messages to me. I understand messages may include information and dates or future appointment or test results.

_____ I do not give practice staff consent to identify themselves and leave messages for me or to text me.

COMMUNICATIONS WITH OTHERS

By signing below, I give permission for my care team to **discuss** my care (including diagnosis, diagnostic test results, examination information, claim information, and appointment confirmations) with the individuals specified below - if the individuals request information or if my care team believes it is in my best interest. This permission is specific to **my <u>current</u> treatment or care at any CMU Health location.**

(1) Name:_____ Relationship/Phone: _____

(2) Name:_____ Relationship/Phone: _____

(3) Name:_____ Relationship/Phone: _____

MAILINGS

_____ I **do** want to receive mailings from my doctor's office at my home address.

_____ I **do not** want to receive any mailings from my doctor's office at my home address. Please send them to my attention at:

_____

I have carefully read and understand all of the above. All of my questions have been answered. I understand that the individuals listed above may continue to receive verbal communications regarding any information they request, and , if I have selected this option, that all mailings will be sent to the address above, until I notify the office, in writing, of my decision to change it.

Patient/Legal Representative Signature: _____ **Date:** _____

Print Name: _____ **Relationship to Patient:** _____

(Rev. 1-23-23)